
Oral Health Work Group

August 11th, 2016

Oregon State Library

Salem, Oregon

The logo for the Oregon Health Authority is centered within a light blue, rounded rectangular background. It features the word "Oregon" in a smaller, orange, serif font positioned above the "H" of the word "Health". The word "Health" is written in a large, blue, serif font. Below "Health", the word "Authority" is written in a smaller, orange, serif font.

Oregon
Health
Authority

Time	Item	Presenter
2:00	Opening remarks	Co-Chairs
2:10	<p>Oral health care access framework model & definition</p> <ul style="list-style-type: none"> • Present draft access framework model and definitions • Q&A and discussion • Finalize framework model and definition 	Matt Sinnott, Co-Chair; Alyssa Franzen, Care Oregon
2:40	<p>Oral health measures – two perspectives</p> <ul style="list-style-type: none"> • Dental Quality Metrics Work Group to the Metrics & Scoring Committee • CCO Oregon Dental Work Group • Q&A 	Eli Schwarz, OHSU Sara Love, CCO Oregon and Matt Sinnott, Willamette Dental Group
3:20	Break	
3:30	Measuring access to oral health care: framing the work	Amanda Peden, OHA
3:40	<p>Indicators of oral health care access</p> <ul style="list-style-type: none"> • Small group activity 	Co-Chairs
4:20	Priority factors of oral health care access	Co-Chairs
4:45	Public Comment	
4:55	Closing comments	Co-Chairs

Meeting objectives

1. Consider, discuss and finalize initial components of oral health care access framework:
 - Oral Health Care Access Framework Model
 - Oral Health Care Access Definition(s)
2. Identify indicators (e.g. patient-to-provider ratios) to assess oral health care access factors
3. Prioritize factors (e.g. provider availability) to assess oral health care access for OHA monitoring purposes

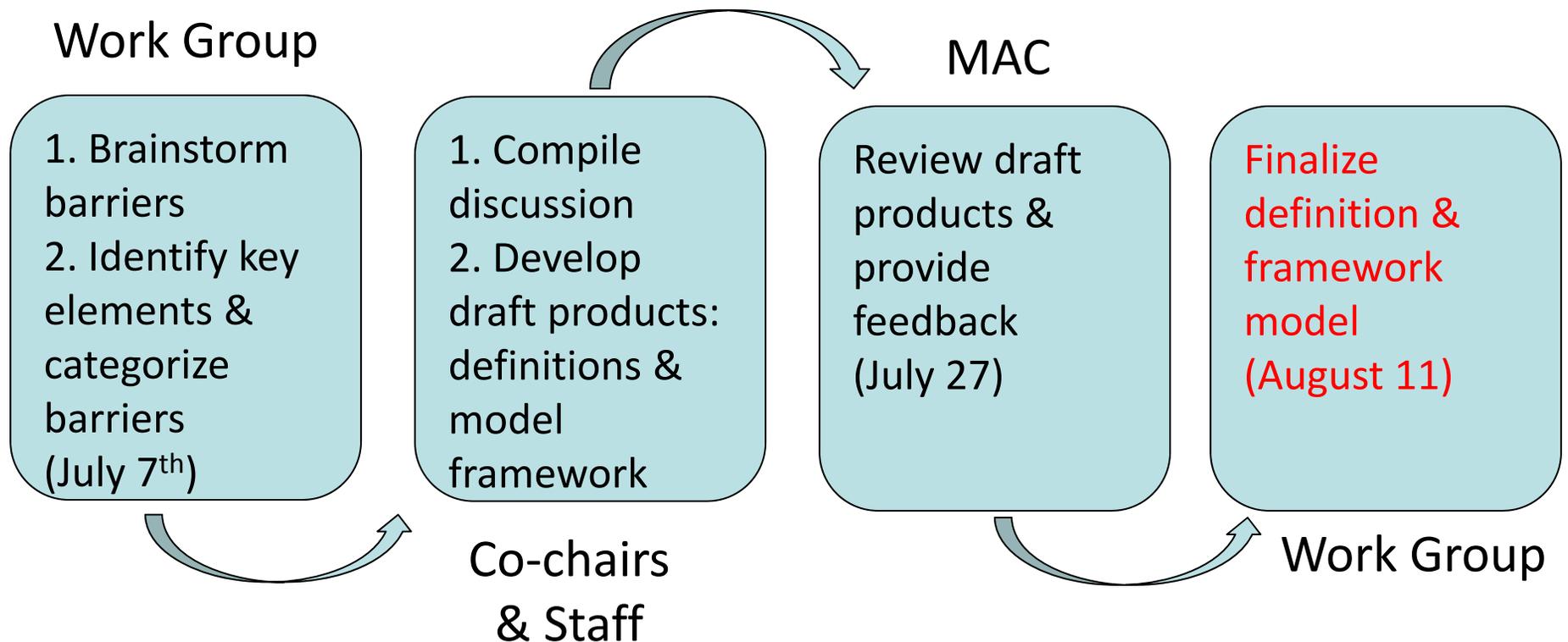
Oral Health Work Group: Progress-to-Date

Matt Sinnott, Willamette Dental Group, Oral
Health Work Group Co-chair

Alyssa Franzen, Care Oregon, MAC Liaison



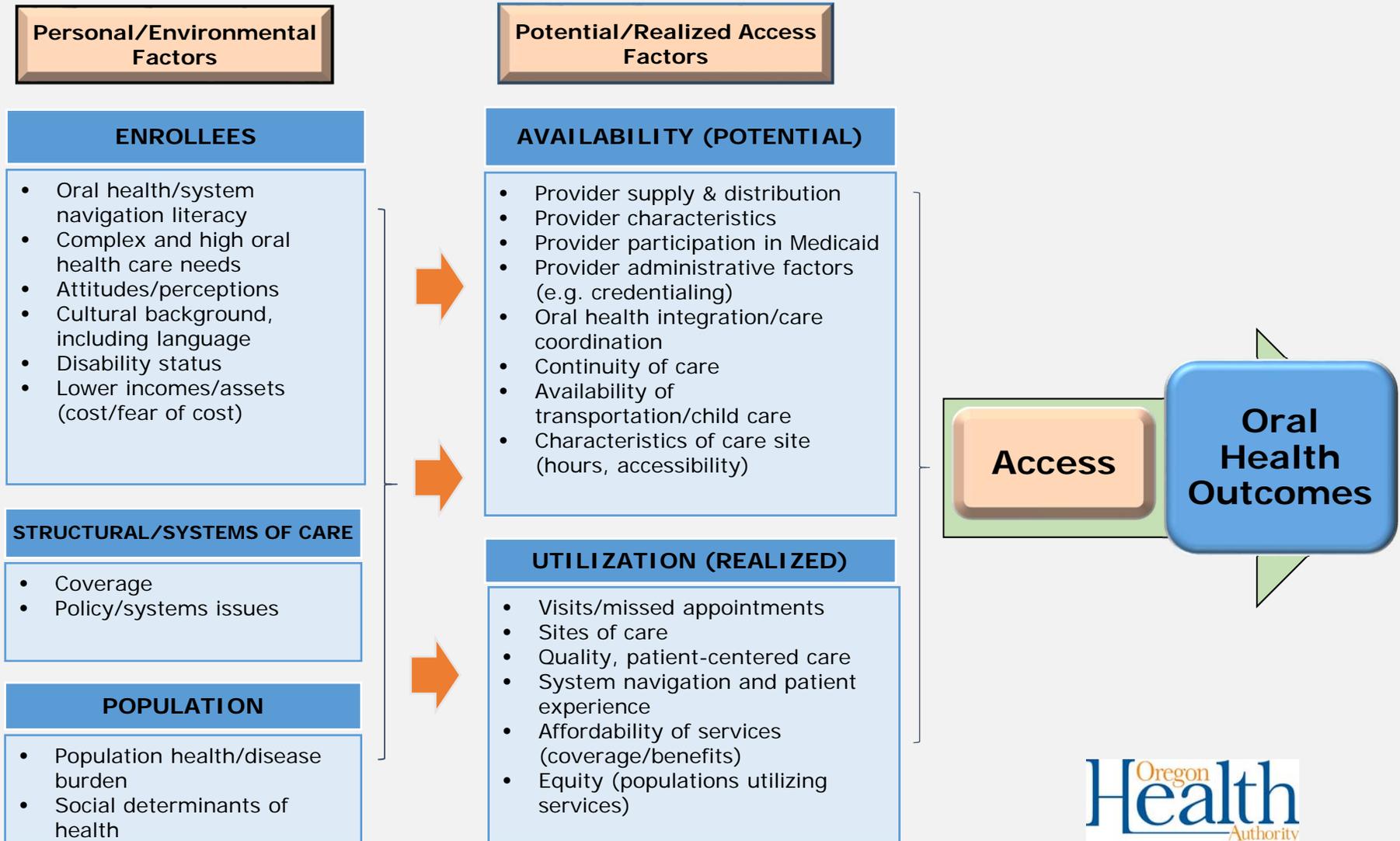
Process: developing the first two products



Key highlights: Medicaid Advisory Committee (MAC) feedback

- Equity – look at access through an equity lens and consider:
 1. Unique personal/enrollee barriers/factors for historically vulnerable and underserved populations (e.g. language, disability status)
 2. Equitable access to services (availability & utilization) for vulnerable and underserved populations, such as racial and ethnic minorities, people with intellectual and physical disabilities, Limited English Proficient (LEP) individuals, pregnant women, special needs children
- Triple Aim - consider integration of dental into physical health and patient-centered primary care

ORAL HEALTH CARE ACCESS FRAMEWORK DRAFT



Proposed definitions of oral health care access in the Oregon Health Plan

Option 1: Oral health care access in the Oregon Health Plan is the availability, affordability, member and caregiver awareness, and timely use of quality oral health services, integrated within a plan for patient-centered overall care at appropriate sites and from qualified providers (including specialists) who meet the needs of individual patients, including oral disease preventive services at regular intervals and treatment services when needed, to reduce disparities and achieve the best possible health outcomes.

Option 2 (short version): Oral health care access in the Oregon Health Plan happens when members (and their caregivers) are aware of, seek, and successfully and equitably receive timely and quality oral health preventive services and needed treatment at appropriate sites and from providers who meet their needs, integrated into a plan for their overall health, in order to produce the best possible health outcomes.

Finalizing the draft framework and definition(s)

Goal: Come to consensus on a final oral health care access framework model and final oral health care access definition(s)

Framework:

- Does the model framework for oral health care access in OHP encompass every element/factor committee members feel should be included?
- Are there additional considerations work group members would like to raise?

Definitions:

- Is there anything missing from the oral health access definitions?
- Does the work group have a preference between the two definitions?

Fist to Five Voting

- **A fist** means, "I vote NO." or in consensus it means , "I object strongly to the proposal."
- **1 finger** means, "I'll just barely go along." or, "I don't like this but it's not quite a no." or, "I think there is lots more work to do on this proposal."
- **2 fingers** means "I don't much like this but I'll go along."
- **3 fingers** means, "I'm in the middle somewhere. Like some of it, but not all."
- **4 fingers** means, "This is fine."
- **5 fingers** means, "I like this a lot, I think it's the best possible decision."

Oral Health Measures: Two Perspectives

Eli Schwarz, OHSU

Sara Love, CCO Oregon

Matt Sinnott, Willamette Dental Group



Guiding questions for presenters

- What was the purpose/goal of the work?
- What considerations/selection criteria you used to guide measure selection?
- What measures, specifically access measures, were recommended?
- What is one access priority you would recommend to this group, based on your experience?

Dental Quality Metrics Work Group

Eli Schwarz, OHSU



Dental Quality Metrics Workgroup

- Convened by OHA in June 2013
- Charged with recommending objective outcome and quality measures and benchmarks for oral health care services provided by CCOs
- Measures incorporated into OHA's measurement framework and recommended for inclusion as a CCO incentive measure in 2015

Workgroup Membership

- Russ Montgomery – All Care Health Plan
- Patrice Korjenek – Trillium
- Janet Meyer – Health Share
- Robert Finkelstein – Willamette Dental Group
- Deborah Loy, Linda Mann – Capitol Dental
- Mike Shirtcliff – Advantage Dental
- Bill Ten Pas – ODS Dental
- Daniel Pihlstrom – Permanente Dental Associates
- Eli Schwarz, Denice Stewart, Mike Plunkett – OHSU School of Dentistry

<http://www.Oregon.gov/oha/Pages/DentalQualityMetrics.ASPX>

Recommended measures should...

- Address adult and pediatric populations;
- Cover multiple domains: prevention, treatment and access;
- Be consistent with existing state and national quality measures

Measure selection criteria

- Representative of the services provided and beneficiaries served by the CCOs;
- Use valid and reliable performance measures;
- Rely on national measures whenever possible;
- Focus on outcomes to the extent possible;
- Exclude measures that would be expected to be heavily influenced by patient case mix;
- Control for the effects of random variation (e.g. measure type, denominator size)

Recommended measures

- Incentive measures:
 - Sealants on permanent molars for children (ADOPTED)
 - Members receiving any dental service
- Monitoring measures:
 - Patient experience with access to dental care (ADOPTED for Oregon CAHPS survey as of 2014)
 - Members with a regular dentist
 - Waiting time to emergency appointment
 - Topical Fluoride Intensity
 - Comprehensive exam rate

Dental Sealant metric – what happened?

\$ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

Dental sealants on permanent molars for children (all ages)
 Percentage of children ages 6-14 who received a dental sealant during the measurement year.

Statewide, dental sealants for children ages 6-14 have increased.

Data source: Administrative (billing) claims
 Benchmark source: Metrics and Scoring Committee consensus

2015 data (n=132,569)

Statewide change since 2014: **+65%**

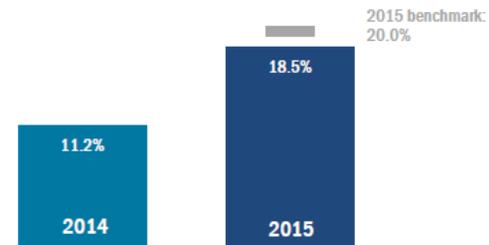
Number of CCOs that improved: **all 16**

Number of CCOs achieving benchmark or improvement target: **all 16**

Dental sealants is a new incentive measure beginning in 2015. A benchmark of 100 percent for this measure is not realistic, due to the limitations of administrative data in identifying teeth that are not candidates for sealants (e.g., those already sealed, not yet erupted, or with active decay).

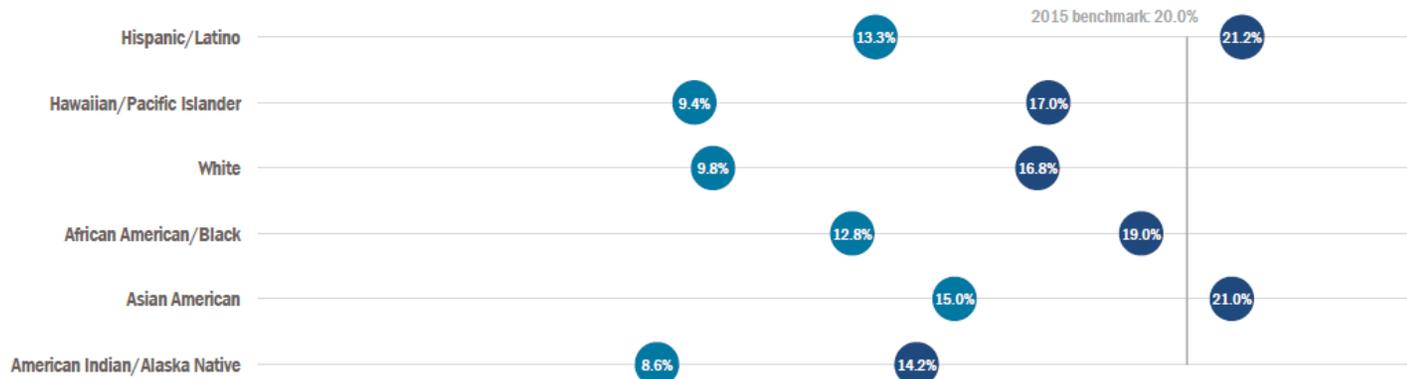
See pages [161](#) and [168](#) for results stratified by members with disability and mental health diagnoses.

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Dental sealants for children ages 6-14 increased across all racial and ethnic groups between 2014 & 2015.

Race and ethnicity data missing for 20.2% of respondents / Each race category excludes Hispanic/Latino

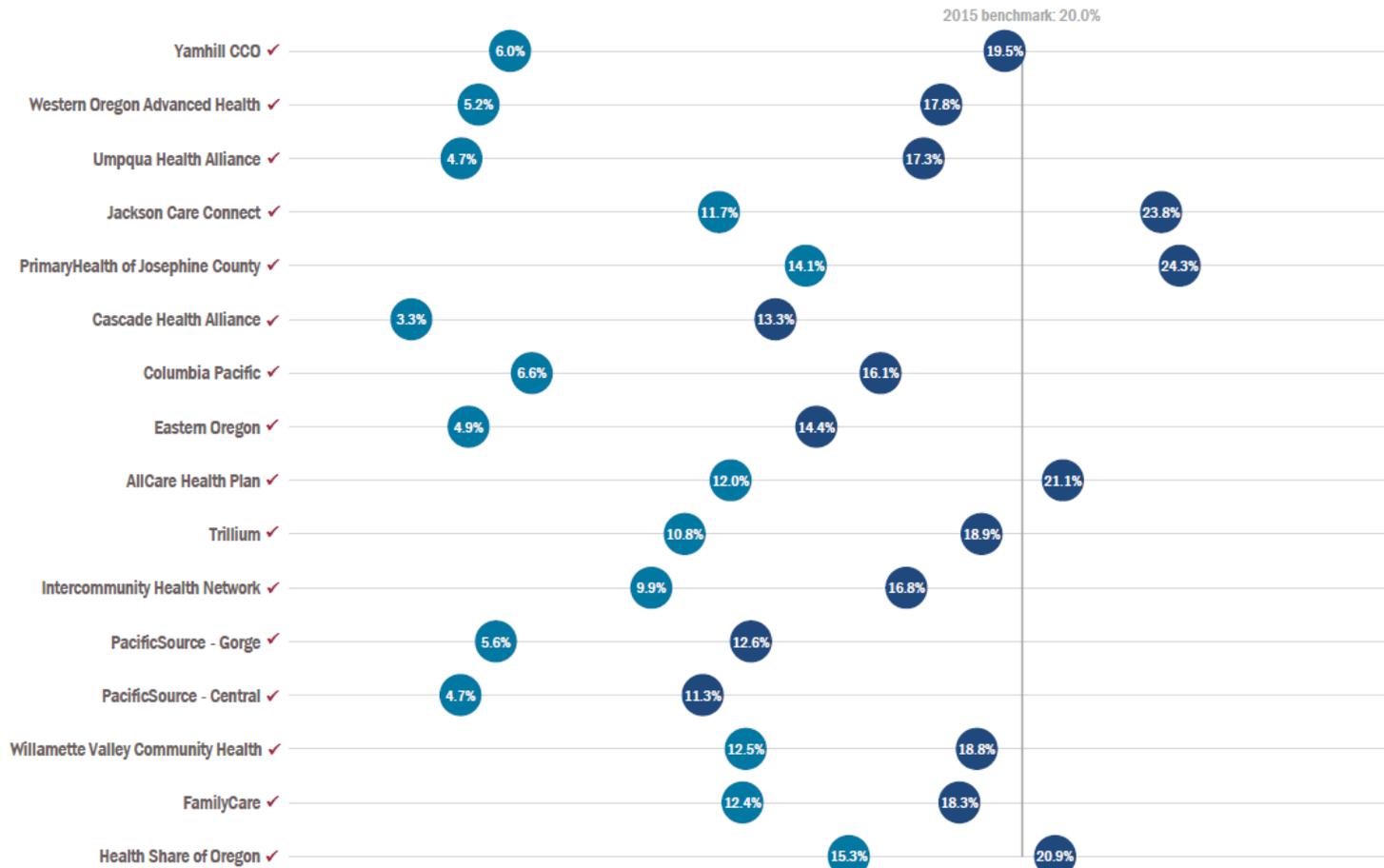


Dental Sealant metric – what happened?

\$ DENTAL SEALANTS ON PERMANENT MOLARS FOR CHILDREN (all ages)

All 16 CCOs achieved benchmark or improvement target for dental sealants between 2014 & 2015.

✓ indicates CCO met benchmark or improvement target



Consumer Assessment of Healthcare Providers and Systems (CAHPS), 2014

ACCESS TO DENTAL CARE

35q. A regular dentist is one you would go to for check-ups and cleanings or when you have a cavity or tooth pain. Do you have a regular dentist?

- Yes
- No

35r. In the last 6 months, if you needed to see a dentist right away because of a dental emergency, did you get to see a dentist as soon as you wanted?

ACCESS TO DENTAL CARE

57a. A regular dentist is one your child would go to for check-ups and cleanings or when he/she has a cavity or tooth pain. Does your child have a regular dentist?

- Yes
- No

57b. In the last 6 months, if your child needed to see a dentist right away because of a dental emergency, did he/she get to see a dentist as soon as you wanted?

Demographic variables: Age, Race, Ethnicity, Health Status, Gender, CCO

Consumer Assessment of Healthcare Providers and Systems (CAHPS), 2014

ACCESS TO DENTAL CARE

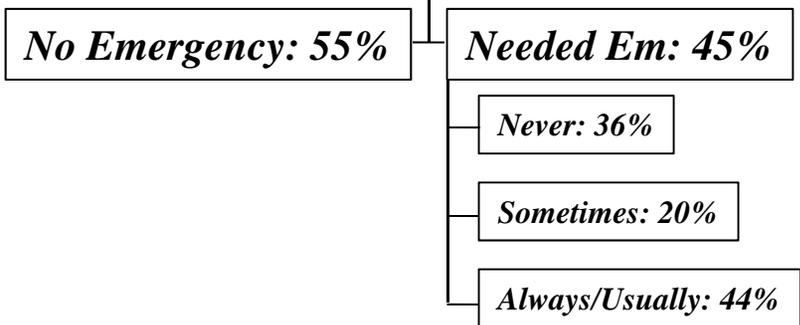
35q. A regular dentist is one you would go to for check-ups and cleanings or when you have a cavity or tooth pain. Do you have a regular dentist?

Yes
 No

Valid cases: 5,025
53%
47%

35r. In the last 6 months, if you needed to see a dentist right away because of a dental emergency, did you get to see a dentist as soon as you wanted?

Valid cases: 4,953



ACCESS TO DENTAL CARE

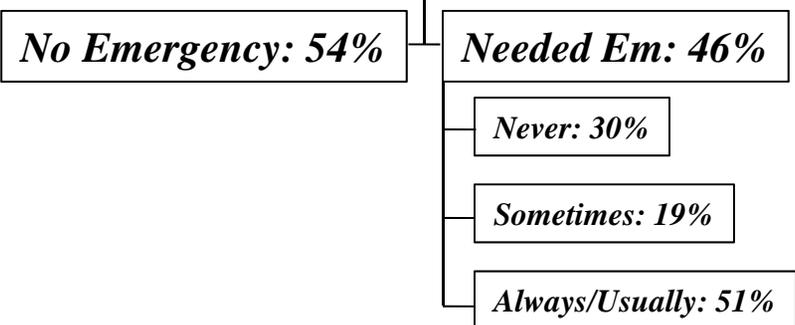
57a. A regular dentist is one your child would go to for check-ups and cleanings or when he/she has a cavity or tooth pain. Does your child have a regular dentist?

Yes
 No

Valid cases: 4,879
79%
21%

57b. In the last 6 months, if your child needed to see a dentist right away because of a dental emergency, did he/she get to see a dentist as soon as you wanted?

Valid cases: 4,909



Demographic variables: Age, Race, Ethnicity, Health Status, Gender, CCO

CCO Oregon Dental Work Group

Sara Love, CCO Oregon

Matt Sinnott, Willamette Dental





Medicaid Advisory Committee

Oral Health Workgroup

August 11, 2016

Sara Love, ND

Matt Sinnott, MHA



CCO Oregon

- Non-profit membership organization focusing on three key areas:
 - Collaboration
 - Research, Analysis, and Reporting
 - Policy Development



Workgroups

- Dental
- Integrated Behavioral Health Alliance of Oregon
- Social Determinants of Health
- Pharmacy



Dental Workgroup

Chair: Matthew Sinnott, MHA, Willamette Dental

Members:

Gary Allen, DMD, Advantage Dental

Teri Barichello, DMD, ODS

Christina Swartz Bodamer, ODA

Tony Finch, Oregon Oral Health Coalition

Alyssa Franzen, DMD, CareOregon

Patty Lane, Trillium CCO

Deborah Loy, Capitol Dental

Sharity Ludwig, EPDH, Advantage Dental

Monica Martinez, JD, CareOregon

Shanie Mason, MPH, CareOregon

Mike Shirtcliff, DMD, Advantage Dental

Heather Simmons, MPH, PacificSource

Eryn Womack, InterCommunity Health Network CCO



Challenges

- Multiple DCO-CCO contracts with different quality measures
- Increased administrative burden for data analytics team to provide accurate reporting
- Measures not always transformative, relevant, or feasible



Process: Striking a Balance

- Uniformity vs flexibility
- Core set with measures considered minimum standards
- À la carte for coordination with local health goals



Results

- Measures that are appropriate for oral health goals and are transformative
- Measures that evaluate appropriate oral health services
- Comprehensive list of measures that evaluate utilization, access, and services for special populations (diabetes, pregnancy, tobacco users)



Core Set Measures

- Utilization
- Preventative Services
- CAHPS-Access to care and patient evaluation
- Emergency Department utilization and follow up



Utilization

- Measurement of enrolled members receiving at least one dental service in the reporting year
- Preventative service measurement for children and pregnant women



Access

CAHPS-Dental Plan Survey

- How often were you're appointments as soon as you wanted?
- How often did you spend more than 15 minutes in the waiting room?
- If you needed to see a dentist immediately for a dental emergency, in the last 12 months, did you get to see a dentist as soon as you wanted?



Questions??

- Contact information:
 - Sara Love, ND
 - sara@ccooregon.org

Measuring Access to Oral Health Care: Framing the Work

Amanda Peden, Oregon Health Authority



Work group charge: Part Two

#2 What key data or information should be used to assess access to oral health services for OHP members (i.e. how should Oregon monitor access to oral health in Medicaid)?

- Identify indicators of oral health care access that tie oral health care access factors (TODAY)
 - Focus on Availability and Utilization to monitor access
- Prioritize oral health care access “factors” for monitoring purposes (TODAY)
- Prioritize existing measures and identify gaps (SEPTEMBER MEETING)

Measuring access: lessons from health care access



Health care access is typically measured in several ways, including:

- Structural measures of the presence or absence of specific resources that facilitate health care (e.g. having health insurance; provider availability; having a usual source of care)
- Assessments by patients of how easily they can gain access to health care (i.e. patient experience measures)
- Utilization measures of the ultimate outcome of good access to care (i.e. the successful receipt of needed/recommended services).

Indicators vs. Measures – what do we mean?

- Indicators = general, conceptual description of measure
- Measures = the way we operationalize indicators to collect specific data (measures include specifications such as population included in the numerator/denominator)

If an indicator is the neighborhood,
the measure is the address

Example: Provider Availability

Availability Factors	Potential Indicators	Potential Measures
Provider supply	Population-to-provider ratios (e.g. Health Professional Shortage Area (HPSA) Designations)	Areas with a population to full-time-equivalent dentist ratio of at least 5,000:1*

Example: Utilization

Availability Factors	Potential Indicators	Potential Measures
Services used	Percentage of enrollees receiving preventive services	Percentage of children receiving at least one preventive dental service by or under the supervision of a dentist within the reporting year

Small Group Activity: Instructions (40 min)

The Oral Health Work Group is charged with identifying indicators of oral health care access in two components of the access framework: availability and utilization.

1. Break into two groups: (1) Availability and (2) Utilization
2. Choose note-taker to submit completed worksheet to OHA
3. Review the list of factors (from the access framework) and the starter list of indicators
4. Brainstorm additional indicators to add to the list, in relation to oral health access factors (use blank rows to record indicators)

➤ Example:

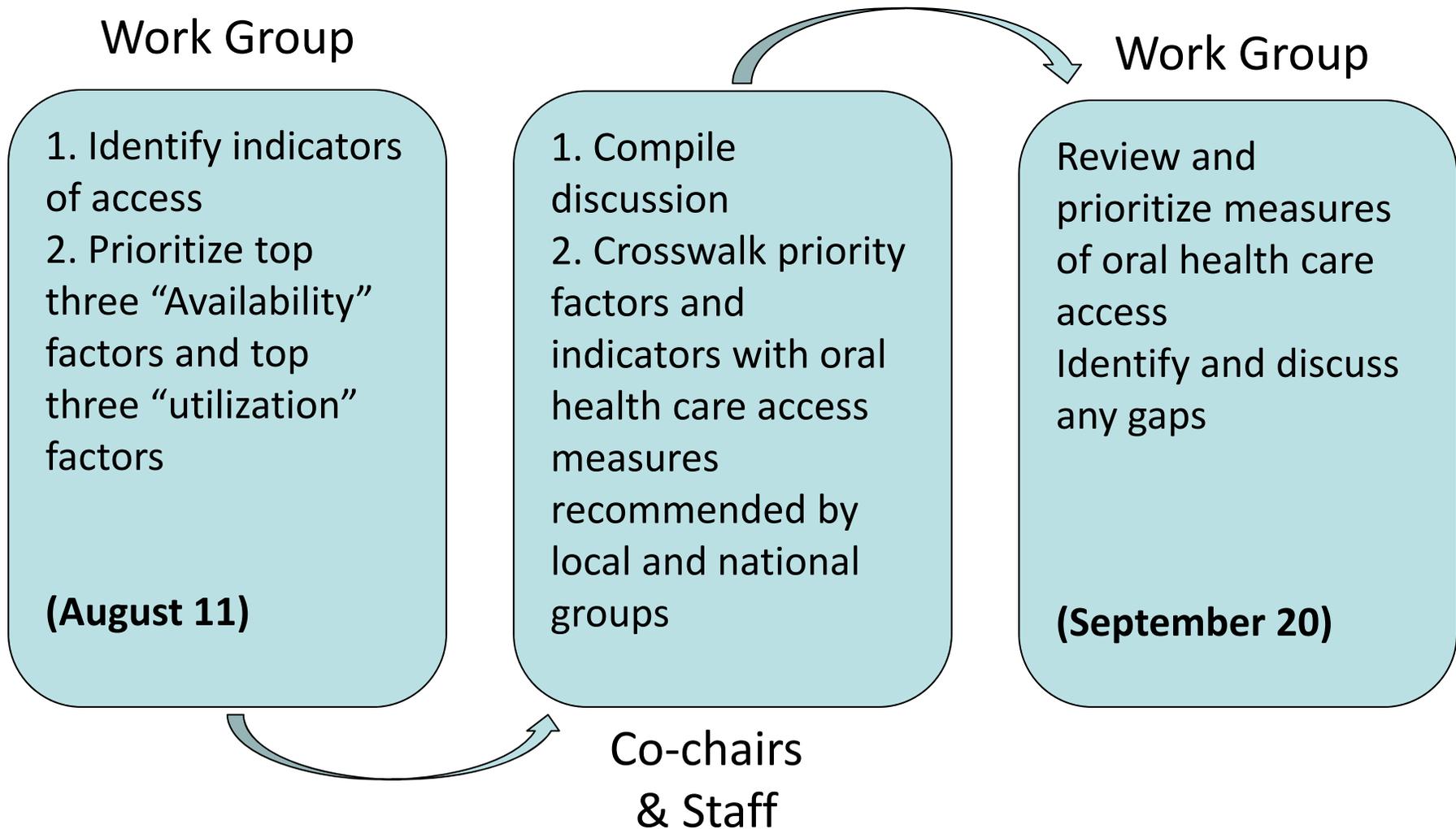
Factor = Provider availability; Indicator = Provider-to-patient ratio

Priority Factors of Oral Health Care Access for the Purpose of Assessing Access

Prioritization Activity



Process: selecting oral health access measures



MAC Considerations for Prioritization of Oral Health Access Factors

The mix of factors should include factors that:

- (1) Support the Triple Aim: importance of care coordination and patient experience as a critical components of oral health care access in Medicaid
- (2) Promote health equity and access for vulnerable and underserved populations within OHP (including people with intellectual and physical disabilities, racial and ethnic minorities, pregnant women, children with special health care needs, and the aging)

Next Steps	Timing
Work Group review and finalize recommended definition and framework model, incorporating MAC feedback; identify indicators of access, prioritize access factors according to MAC guidelines	TODAY
<p>Staff and co-chairs identify existing access measures, recommended by local and national groups to cross-walk with Oral Health Work Group identified priorities</p> <p><i>MAC Consideration for measures: Be consistent with recommendations of stakeholder groups (e.g. Dental Quality Metrics Work Group, CCO Oregon Dental Work Group)</i></p>	August
Work Group select measures, identify gaps, discuss final recommendations to MAC	September 20
MAC discuss and finalize memo to OHA regarding a framework for access to oral health care in OHP	September 28
<p><i>Work Group opportunity to provide feedback on oral health integration in Oregon</i></p> <p><i>AS NEEDED: Work Group discuss any significant recommendations from MAC and propose revised final recommendations</i></p>	October TBD Two Hours